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Bill no.: Committee Print
Amendment no.: 1
Date offered: 10/27/05
Disposition: Agreed to, as amended, by VV

AMENDMENT TO COMMITTEE PRINT OF OCTOBER 21, 2005

OFFERED BY MR. BARTON OF TEXAS

Amend subtitle A to read as follows:

Subtitle A—Medicaid

Subtitle A—Medicaid

SEC. 3100. SHORT TITLE OF SUBTITLE; RULE OF CONSTRUCTION WITH REGARD TO KATRINA EVACUEES.

(a) SHORT TITLE.—This subtitle may be cited as the "Medicaid Reconciliation Act of 2005".

(b) RULE OF CONSTRUCTION WITH REGARD TO KATRINA EVACUEES.—None of the provisions of the following chapters of this subtitle shall apply during the 11-month period beginning September 1, 2005, to individuals entitled to medical assistance under title XIX of the Social Security Act by reason of their residence in a parish in the State of Louisiana, or a county in the State of Mississippi or Alabama, for which a major disaster has been declared in accordance with section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5170) as a result of Hurricane Katrina and which the President has determined, before September 14, 2005, warrants individual and public assistance from the Federal Government under such Act.

CHAPTER 1—PAYMENT FOR PRESCRIPTION DRUGS

SEC. 3101. FEDERAL UPPER LIMIT (FUL).

(a) IN GENERAL.—Subsection (e) of section 1927 of the Social Security Act (42 U.S.C. 1396r–8) is amended to read as follows:

"(e) PHARMACY REIMBURSEMENT LIMITS.—

"(1) FEDERAL UPPER LIMIT FOR INGREDIENT COST OF COVERED OUTPATIENT DRUGS.—

"(A) IN GENERAL.—Subject to subparagraph (B), no Federal financial participation shall be available for payment for the ingredient cost of a covered outpatient drug in excess of the Federal upper limit for that drug established under paragraph (2).

"(B) OPTIONAL CARVE OUT.—A State may elect not to apply subparagraph (A) to payment for either or both of the following:

"(i) Drugs dispensed by specialty pharmacies (such as those dispensing only immunosuppressive drugs), as defined by the Secretary.

"(ii) Drugs administered by a physician in a physician's office.

"(2) FEDERAL UPPER LIMIT.—

"(A) IN GENERAL.—Except as provided in subparagraph (D) and subject to paragraph (5), the Federal upper limit established under this paragraph for the ingredient cost of a—

"(i) single source drug, is 106 percent of the RAMP (as defined in subparagraph (B)(i)) for that drug; and

"(ii) multiple source drug, is 120 percent of the volume weighted average RAMP (as defined under subparagraph (C)) for that drug.

A drug product that is a single source drug and that becomes a multiple source drug shall continue to be treated under this subsection as a single source drug until the Secretary determines that there is sufficient data to compile the volume weighted average RAMP for that drug.

"(B) RAMP AND RELATED PROVISIONS.—For purposes of this subsection:

"(i) RAMP DEFINED.—The term 'RAMP' means, with respect to a covered outpatient drug by a manufacturer for a calendar quarter and subject to clause (ii) and (iii), the average price paid to a manu-

facturer for the drug in the United States in the quarter by wholesalers for drugs distributed to retail pharmacies, excluding—

"(I) customary prompt pay discounts; and

"(II) service fees that are paid by the manufacturer to an entity and that represent fair market value for a bona-fide service provided by the entity.

"(ii) SALES EXEMPTED FROM COMPUTATION.—The RAMP under clause (i) shall exclude any of the following:

"(I) Sales exempt from inclusion in the determination of best price under subsection (c)(1)(C)(i).

"(II) Such other sales as the Secretary identifies as sales to an entity that are merely nominal in amount under subsection (c)(1)(C)(ii)(III).

"(iii) SALE PRICE NET OF DISCOUNTS.—In calculating the RAMP under clause (i), such RAMP shall include any of the following:

"(I) Cash discounts and volume discounts.

"(II) Free goods that are contingent upon any purchase requirement.

"(III) Sales at a nominal price that are contingent upon any purchase requirement or agreement.

"(IV) Chargebacks, rebates (not including rebates provided under an agreement under this section), or any other direct or indirect discounts.

"(V) Any other price concessions, which may be based on recommendations of the Inspector General of the Department of Health and Human Services, that would result in a reduction of the cost to the purchaser.

"(iv) RETAIL PHARMACY.—For purposes of this subsection, the term 'retail pharmacy' does not include mail-order only pharmacies or any pharmacy at a nursing facility or home.

"(C) VOLUME WEIGHTED AVERAGE RAMP DEFINED.—For purposes of subparagraph (A), for all drug products included within the same

multiple source drug billing and payment code (or such other methodology as may be specified by the Secretary), the volume weighted average RAMP is the volume weighted average of the RAMPs reported under section 1927(b)(3)(A)(iv) determined by—

(i) computing the sum of the products (for each National Drug Code assigned to such drug products) of—

(I) the manufacturer's RAMP (as defined in subparagraph (B)); and

(II) the total number of units specified under section 1847A(b)(2) sold; and

(ii) dividing the sum determined under clause (i) by the sum of the total number of units under clause (i)(II) for all National Drug Codes assigned to such drug products.

"(D) EXCEPTION FOR INITIAL SALES PERIODS.—

"(i) IN GENERAL.—In the case of a single source drug during an initial sales period (not to exceed 2 calendar quarters) in which data on sales for the drug are not

sufficiently available from the manufacturer to compute the RAMP or the weighted average RAMP under subparagraph (C), the Federal upper limit for the ingredient cost of such drug during such period shall be the wholesale acquisition cost (as defined in clause (ii)) for the drug.

"(ii) WHOLESALE ACQUISITION COST.—For purposes of clause (i), the term 'wholesale acquisition cost' means, with respect to a drug or biological, the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

"(E) UPDATES; DATA COLLECTION.—

"(i) FREQUENCY OF DETERMINATION.—The Secretary shall update the Federal upper limits applicable under this paragraph on at least a quarterly basis,

taking into account the most recent data collected for purposes of determining such limits and the Food and Drug Administration's most recent publication of 'Approved Drug Products with Therapeutic Equivalence Evaluations'.

"(ii) COLLECTION OF DATA.—Data on RAMP is collected under subsection (b)(3)(A)(iv).

"(F) AUTHORITY TO ENTER CONTRACTS.—The Secretary may enter into contracts with appropriate entities to determine RAMPS and other data necessary to calculate the Federal upper limit for a covered outpatient drug established under this subsection and to calculate that payment limit.

"(3) DISPENSING FEES.—

"(A) IN GENERAL.—A State which provides medical assistance for covered outpatient drugs shall pay a dispensing fee for each covered outpatient drug in accordance with this paragraph. A State may vary the amount of such dispensing fees, including taking into account the special circumstances of pharmacies that are serving rural or underserved areas or

that are sole community pharmacies, so long as such variation is consistent with subparagraph (B).

"(B) DISPENSING FEE PAYMENT FOR MULTIPLE SOURCE DRUGS.—A State shall establish a dispensing fee under this title for a covered outpatient drug that is treated as a multiple source drug under paragraph (2)(A) (whether or not it may be an innovator multiple source drug) in an amount that is not less than $8 per prescription unit. The Secretary shall define what constitutes a prescription unit for purposes of the previous sentence.

"(4) EFFECT ON STATE MAXIMUM ALLOWABLE COST LIMITATIONS.—This section shall not supersede or affect provisions in effect prior to January 1, 1991, or after December 31, 1994, relating to any maximum allowable cost limitation established by a State for payment by the State for covered outpatient drugs, and rebates shall be made under this section without regard to whether or not payment by the State for such drugs is subject to such a limitation or the amount of such a limitation.

"(5) EVALUATION OF USE OF RETAIL SURVEY PRICE METHODOLOGY.—

"(A) IN GENERAL.—The Secretary may develop a methodology to set the Federal upper limit based on the reported retail survey price, as most recently reported under subparagraph (C), instead of a percentage of RAMP or volume weighted average RAMP as described in paragraph (2).

"(B) INITIAL APPLICATION.—For 2007, the Secretary may use this methodology for a limited number of covered outpatient drugs, including both single source and multiple source drugs, selected by the Secretary in a manner so as to representative of the classes of drugs dispensed under this title.

"(C) DETERMINATION OF RETAIL SURVEY PRICE FOR COVERED OUTPATIENT DRUGS.—

"(i) USE OF VENDOR.—The Secretary may contract services for the determination of retail survey prices for covered outpatient drugs that represent a nationwide average of pharmacy sales costs for such drugs, net of all discounts and rebates. Such a contract shall be awarded for a term of 2 years.

"(ii) USE OF COMPETITIVE BIDDING.—In contracting for such services, the Secretary shall competitively bid for an outside vendor that has a demonstrated history in—

"(I) surveying and determining, on a representative nationwide basis, retail prices for ingredient costs of prescription drugs;

"(II) working with retail pharmacies, commercial payors, and States in obtaining and disseminating such price information; and

"(III) collecting and reporting such price information on at least a monthly basis.

"(iii) ADDITIONAL PROVISIONS.—A contract with a vendor under this subparagraph shall include such terms and conditions as the Secretary shall specify, including the following:

"(I) The vendor must monitor the marketplace and report to Secretary each time there is a new cov-

ered outpatient drug available nationwide.

"(II) The vendor must update the Secretary no less often than monthly on the retail survey prices for multiple source drugs.

"(III) The vendor must apply methods for independently confirming retail survey prices.

"(iv) AVAILABILITY OF INFORMATION TO STATES.—Information on retail survey prices obtained under this subparagraph, including applicable information on single source drugs, shall be provided to States on an ongoing, timely basis.

"(D) STATE USE OF RETAIL SURVEY PRICE DATA.—

"(i) DISTRIBUTION OF PRICE DATA.—The Secretary shall devise and implement a means for electronic distribution to each State agency designated under 1902(a)(5) with responsibility for the administration or supervision of the administration of the State plan under this title of the retail survey price determined under this paragraph.

"(ii) AUTHORITY TO ESTABLISH PAYMENT RATES BASED ON DATA.—A State may use the price data received in accordance with clause (ii) in establishing payment rates for the ingredient costs and dispensing fees for covered outpatient drugs dispensed to individuals eligible for medical assistance under this title.

"(6) LIMITATION ON JUDICIAL REVIEW.—There shall be no administrative or judicial review of—

"(A) the Secretary's determinations of Federal upper limits, RAMPs, and volume weighted average RAMPs under this subsection, including the assignment of National Drug Codes to billing and payment classes;

"(B) the Secretary's disclosure to States of the average manufacturer price, RAMP, volume weighted average RAMP, and retail survey price;

"(C) determinations under this subsection by the Secretary of covered outpatient drugs which are dispensed by a specialty pharmacy or administered by a physician in a physician's office;

"(D) the contracting and calculations process under this subsection.

"(E) the method to allocate rebates, chargebacks, and other price concessions to a quarter if specified by the Secretary.".

(b) CONFORMING AMENDMENTS.—

(1) REPORTING RAMP-RELATED INFORMATION.—Subsection (b)(3)(A) of such section is amended—

(A) by striking "and" at the end of clause (ii);

(B) by striking the period at the end of clause (iii) and inserting "; and"; and

(C) by inserting after clause (iii) the following new clause:

"(iv) for calendar quarters beginning on or after July 1, 2006, in conjunction with reporting required under clause (i) and by National Drug Code (including package size)—

"(I) the manufacturer's RAMP (as defined in subsection (e)(2)(B)(i)) and the total number of units required to compute the volume weighted average RAMP under subsection (e)(2)(C);

"(II) if required to make payment under subsection (e)(2)(D), the manufacturer's wholesale acquisition cost, as defined in clause (ii) of such subsection; and

"(III) information on those sales that were made at a nominal price or otherwise described in subsection (e)(2)(B)(ii)(II);

for all covered outpatient drugs.".

(2) DISCLOSURE TO STATES.—Subsection (b)(3)(D) of such section is amended—

(A) by striking "and" at the end of clause (ii);

(B) by striking the period at the end of clause (iii) and inserting ", and"; and

(C) by inserting after clause (iv) the following new clause:

"(iv) to States to carry out this title.".

(3) LIMITATIONS ON FEDERAL FINANCIAL PARTICIPATION.—Section 1903(i) of such Act (42 U.S.C. 1396b(i)) is amended—

(A) in paragraph (10)(A), by striking "and" at the end;

(B) in paragraph (10)(B), by striking "or" at the end and inserting "and";

(C) by adding at the end of paragraph (10) the following:

"(C) with respect to any amount expended for the ingredient cost of a covered outpatient drug that exceeds the Federal upper limit for that drug established and applied under section 1927(e); or"; and

(D) in paragraph (21), as inserted by section 104(b) of Public Law 109-91, by inserting before the period at the end the following: "or described in subparagraph (B) or (C) of section 1927(d)(2)"..

(c) EFFECTIVE DATE.—The amendments made by this section take effect with respect to a State on the later of—

(1) January 1, 2007; or

(2) the date that is 6 months after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

(d) GAO STUDY ON DISPENSING FEES.—The Comptroller General of the United States shall conduct a study on the appropriateness in payment levels to pharmacies for dispensing fees under the medicaid program, including payment to specialty pharmacies. Not later than 9 months

after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on such study.

(e) IG REPORT ON USE OF RAMP AND RETAIL SURVEY PRICES.—Not later than 2 years after the date of the enactment of this Act, the Inspector General in the Department of Health and Human Services shall submit to Congress a report on the appropriateness of using the RAMP and retail survey prices, rather than the average manufacturer price or other price measures, as the basis for establishing a Federal upper limit for reimbursement for covered outpatient drugs under the medicaid program.

SEC. 3102. COLLECTION AND SUBMISSION OF UTILIZATION DATA FOR CERTAIN PHYSICIAN ADMINISTERED DRUGS.

(a) IN GENERAL.—Section 1927(a) of the Social Security Act (42 U.S.C. 1396r–8(a)) is amended by adding at the end the following new paragraph:

"(7) REQUIREMENT FOR SUBMISSION OF UTILIZATION DATA FOR CERTAIN PHYSICIAN ADMINISTERED DRUGS.—

"(A) SINGLE SOURCE DRUGS.—In order for payment to be available under section 1903(a) for a covered outpatient drug that is a single source drug or biological that is physician

administered (as determined by the Secretary), and that is administered on or after January 1, 2006, the State shall provide for the submission of such utilization data and coding (such as J-codes and National Drug Code numbers) for each such drug as the Secretary may specify as necessary to identify the manufacturer of the drug in order to secure rebates under this section for drugs administered for which payment is made under this title.

"(B) MULTIPLE SOURCE DRUGS.—

"(i) IN GENERAL.—Not later than January 1, 2007, the information shall be submitted under subparagraph (A) using National Drug Code codes unless the Secretary specifies that an alternative coding system should be used.

"(ii) IDENTIFICATION OF MOST FREQUENTLY PHYSICIAN ADMINISTERED MULTIPLE SOURCE DRUGS.—Not later than January 1, 2007, the Secretary shall publish a list of the 20 physician administered multiple source drugs that the Secretary determines have the highest dollar volume of physician administered dispensing under

this title. The Secretary may modify such list from year to year to reflect changes in such volume.

"(iii) REQUIREMENT.—In order for payment to be available under section 1903(a) for a covered outpatient drug that is a multiple source drug that is physician administered (as determined by the Secretary), that is on the list published under clause (ii), and that is administered on or after January 1, 2008, the State shall provide for the submission of such utilization data and coding (such as J-codes and National Drug Code numbers) for each such drug as the Secretary may specify as necessary to identify the manufacturer of the drug in order to secure rebates under this section.

"(C) HARDSHIP WAIVER.—The Secretary may delay the application of subparagraph (A) or (B), or both, in the case of a State to prevent hardship to States which require additional time to implement the reporting system required under the respective subparagraph.".

(b) LIMITATION ON PAYMENT.—Section 1903(i)(10) of such Act (42 U.S.C. 1396b(i)(10)), as amended by section 3101(b)(2), is amended—

(1) by striking "and" at the end of subparagraph (B);

(2) by striking "; or" at the end of subparagraph (C) and inserting ", and"; and

(3) by adding at the end the following new subparagraph:

"(D) with respect to covered outpatient drugs described in section 1927(a)(7), unless information respecting utilization data and coding on such drugs that is required to be submitted under such section is submitted in accordance with such section; or".

SEC. 3103. IMPROVED REGULATION OF DRUGS SOLD UNDER A NEW DRUG APPLICATION APPROVED UNDER SECTION 505(C) OF THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.

(a) INCLUSION WITH OTHER REPORTED AVERAGE MANUFACTURER AND BEST PRICES.—Section 1927(b)(3)(A) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)(A)) is amended—

(1) by striking clause (i) and inserting the following:

"(i) not later than 30 days after the last day of each rebate period under the agreement—

"(I) on the average manufacturer price (as defined in subsection (k)(1)) for covered outpatient drugs for the rebate period under the agreement (including for all such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act); and

"(II) for single source drugs and innovator multiple source drugs (including all such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act), on the manufacturer's best price (as defined in subsection (c)(1)(C)) for such drugs for the rebate period under the agreement;"; and

(2) in clause (ii), by inserting "(including for such drugs that are sold under a new drug applica-

tion approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act)" after "drugs".

(b) CONFORMING AMENDMENTS.—Section 1927 of such Act (42 U.S.C. 1396r–8) is amended—

(1) in subsection (c)(1)(C)—

(A) in clause (i), in the matter preceding subclause (I), by inserting after "or innovator multiple source drug of a manufacturer" the following: "(including any other such drug of a manufacturer that is sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act)"; and

(B) in clause (ii)—

(i) in subclause (II), by striking "and" at the end;

(ii) in subclause (III), by striking the period at the end and inserting "; and"; and

(iii) by adding at the end the following:

"(IV) in the case of a manufacturer that approves, allows, or otherwise permits any other drug of the manufacturer to be sold under a new drug application approved under sec-

tion 505(c) of the Federal Food, Drug, and Cosmetic Act, shall be inclusive of the lowest price for such authorized drug available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, excluding those prices described in subclauses (I) through (IV) of clause (i).''; and

(2) in subsection (k)—

(A) in paragraph (1)—

(i) by striking ''The term'' and inserting the following:

''(A) IN GENERAL.—The term''; and

(ii) by adding at the end the following:

''(B) INCLUSION OF SECTION 505(C) DRUGS.—In the case of a manufacturer that approves, allows, or otherwise permits a any drug of the manufacturer to be sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act, such term shall be inclusive of the

average price paid for such authorized drug by wholesalers for drugs distributed to the retail pharmacy class of trade, after deducting customary prompt pay discounts.".

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act.

CHAPTER 2—REFORM OF ASSET TRANSFER RULES

SEC. 3111. LENGTHENING LOOK-BACK PERIOD; CHANGE IN BEGINNING DATE FOR PERIOD OF INELIGIBILITY.

(a) LENGTHENING LOOK-BACK PERIOD FOR ALL DISPOSALS TO 5 YEARS.—Section 1917(c)(1)(B)(i) of the Social Security Act (42 U.S.C. 1396p(c)(1)(B)(i)) is amended by inserting "or in the case of any other disposal of assets made on or after the date of the enactment of the Medicaid Reconciliation Act of 2005" before ", 60 months".

(b) CHANGE IN BEGINNING DATE FOR PERIOD OF INELIGIBILITY.—Section 1917(c)(1)(D) of such Act (42 U.S.C. 1396p(c)(1)(D)) is amended—

(1) by striking "(D) The date" and inserting "(D)(i) In the case of a transfer of asset made be-

fore the date of the enactment of the Medicaid Reconciliation Act of 2005, the date"; and

(2) by adding at the end the following new clause:

"(ii) In the case of a transfer of asset made on or after the date of the enactment of the Medicaid Reconciliation Act of 2005, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and is receiving services described in subparagraph (C), whichever is later, and which does not occur during any other period of ineligibility under this subsection.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to transfers made on or after the date of the enactment of this Act.

(d) AVAILABILITY OF HARDSHIP WAIVERS.—Each State shall provide for a hardship waiver process in accordance with section 1917(c)(2)(D) of the Social Security Act (42 U.S.C. 1396p(c)(2)(D))—

(1) under which an undue hardship exists when application of the transfer of assets provision would deprive the individual—

(A) of medical care such that the individual's health or life would be endangered; or

(B) of food, clothing, shelter, or other necessities of life; and

(2) which provides for—

(A) notice to recipients that an undue hardship exception exists;

(B) a timely process for determining whether an undue hardship waiver will be granted; and

(C) a process under which an adverse determination can be appealed.

(e) ADDITIONAL PROVISIONS ON HARDSHIP WAIVERS.—

(1) APPLICATION BY FACILITY.—Section 1917(c)(2) of the Social Security Act (42 U.S.C. 1396p(c)(2)) is amended—

(A) by striking the semicolon at the end of subparagraph (D) and inserting a period; and

(B) by adding after and below such subparagraph the following:

"The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver applica-

tion on behalf of the individual with the consent of the individual or the legal guardian of the individual.".

(2) AUTHORITY TO MAKE BED HOLD PAYMENTS FOR HARDSHIP APPLICANTS.—Such section is further amended by adding at the end the following: "While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.".

SEC. 3112. DISCLOSURE AND TREATMENT OF ANNUITIES AND OF LARGE TRANSACTIONS.

(a) IN GENERAL.—Section 1917 of the Social Security Act is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

"(e)(1) In order to meet the requirements of this subsection for purposes of section 1902(a)(18), a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) (relating to long-term care services) for an individual, the application of the individual for such assistance (including

any recertification of eligibility for such assistance) shall disclose the following:

"(A) A description of any interest the individual has in an annuity (or similar financial instrument which provides for the conversion of a countable asset to a noncountable asset, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset.

"(B) Full information (as specified by the Secretary) concerning any transaction involving the transfer or disposal of assets during the previous period of 60 months, if the transaction exceeded $100,000, without regard to whether the transfer or disposal was for fair market value. For purposes of applying the previous sentence under this subsection, all transactions of $5,000 or more occurring within a 12-month period shall be treated as a single transaction. The dollar amounts specified in the first and second sentences of this subparagraph shall be increased, beginning with 2007, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000 in the case of the first sentence and $100 in the case of the second sentence.

Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such a annuity or similar financial instrument by virtue of the provision of such medical assistance.

"(2)(A) In the case of any annuity in which an institutionalized individual has an interest, if medical assistance is furnished to the individual for services described in subsection (c)(1)(C)(i), by virtue of the provision of such assistance the State becomes the remainder beneficiary in the first position for the total amount of such medical assistance paid on behalf of the individual under this title.

"(B) In the case of disclosure concerning an annuity under paragraph (1)(A), the State shall notify issuer of the annuity of the right of the State under subparagraph (A) as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under subparagraph (A).

"(C) In the case of such an issuer receiving notice under subparagraph (B), the State may require the issuer to notify the State when there is a change in the amount

of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1)(A). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

"(3)(A) For purposes of subsection (c)(1), a transaction described in paragraph (1)(B) shall be deemed as the transfer of an asset for less than fair market value unless the individual demonstrates to the satisfaction of the State that the transfer of the asset was for fair market value.

"(B) The Secretary may provide guidance to States on categories of arms length transactions (such as the purchase of a commercial annuity) that could be generally treated as a transfer of asset for fair market value.

"(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1)(A).".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to transactions (including the purchase of an annuity) occurring on or after the date of the enactment of this Act.

SEC. 3113. APPLICATION OF "INCOME-FIRST" RULE IN APPLYING COMMUNITY SPOUSE'S INCOME BEFORE ASSETS IN PROVIDING SUPPORT OF COMMUNITY SPOUSE.

(a) IN GENERAL.—Section 1924(d) of the Social Security Act (42 U.S.C. 1396r–5(d)) is amended by adding at the end the following new paragraph:

"(6) APPLICATION OF 'INCOME FIRST' RULE FOR FUNDING COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE.—For purposes of this subsection and subsection (e), any transfer or allocation made from an institutionalized spouse to meet the need of a community spouse for a community spouse monthly income allowance under paragraph (1)(B) shall be first made from income of the institutionalized spouse and then only when the income is not available from the resources of such institutionalized spouse.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to transfers and allocations made on or after the date of the enactment of this Act by individuals who become institutionalized spouses on or after such date.

SEC. 3114. DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY.

(a) IN GENERAL.—Section 1917 of the Social Security Act, as amended by section 3112, is further amended by redesignating subsection (f) as subsection (g) and by inserting after subsection (e) the following new subsection:

"(f)(1) Notwithstanding any other provision of this title, subject to paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if individual's equity interest in the individual's home exceeds $500,000. The dollar amount specified in the preceding sentence shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

"(2) Paragraph (1) shall not apply with respect to an individual if—

"(A) the spouse of such individual, or

"(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with

respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614,

is lawfully residing in the individual's home.

"(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

"(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to individuals who are determined eligible for medical assistance with respect to nursing facility services or other long-term care services based on an application filed on or after January 1, 2006.

SEC. 3115. ENFORCEABILITY OF CONTINUING CARE RETIREMENT COMMUNITIES (CCRC) AND LIFE CARE COMMUNITY ADMISSION CONTRACTS.

(a) ADMISSION POLICIES OF NURSING FACILITIES.—Section 1919(c)(5) of the Social Security Act (42 U.S.C. 1396r(c)(5)) is amended—

(1) in subparagraph (A)(i)(II), by inserting "subject to clause (v)," after "(II)"; and

(2) by adding at the end the following new clause:

"(v) TREATMENT OF CONTINUING CARE RETIREMENT COMMUNITIES ADMISSION CONTRACTS.—Notwithstanding subclause (II) of subparagraph (A)(i), subject to section 1924(c), contracts for admission to a State licensed, registered, certified, or equivalent continuing care retirement community or life care community, including services in a nursing facility that is part of such community, may require residents to spend on their care resources declared for the purposes of admission before applying for medical assistance.".

(b) TREATMENT OF ENTRANCE FEES.—Section 1917 of such Act (42 U.S.C. 1396p) is amended by adding at the end the following new subsection:

"(f) TREATMENT OF ENTRANCE FEES OF INDIVIDUALS RESIDING IN CONTINUING CARE RETIREMENT COMMUNITIES.—

"(1) IN GENERAL.—For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this title, the rules specified in paragraph (2) shall apply to individuals

residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

"(2) TREATMENT OF ENTRANCE FEE.—For purposes of this subsection, an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that—

"(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

"(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

"(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

"(3) TREATMENT IN RELATION TO SPOUSAL SHARE.—To the extent that an entrance fee is determined to be an available resource to an individual applying for medical assistance and the individual

has a community spouse as defined in section 1924(h), the entrance fee shall be considered in the computation of spousal share pursuant to section 1924(c).".

CHAPTER 3—FLEXIBILITY IN COST-SHARING AND BENEFITS

SEC. 3121. STATE OPTION FOR ALTERNATIVE MEDICAID PREMIUMS AND COST-SHARING.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by inserting after section 1916 the following new section:

"STATE OPTION FOR ALTERNATIVE PREMIUMS AND COST-SHARING

"SEC. 1916A. (a) STATE FLEXIBILITY.—

"(1) IN GENERAL.—Notwithstanding sections 1916 and 1902(a)(10)(B), a State, at its option and through a State plan amendment, may impose premiums and cost-sharing for any group of individuals (as specified by the State) and for any type of services (and may vary such premiums and cost-sharing among such group or type, including through the use of tiered cost-sharing for prescription drugs) consistent with the limitations established under this section. Nothing in this section shall be construed as superseding (or preventing the application of) section 1916(g).

"(2) DEFINITIONS.—In this section:

"(A) PREMIUM.—The term 'premium' includes any enrollment fee or similar charge.

"(B) COST-SHARING.—The term 'cost-sharing' includes any deduction, deductible, co-payment, or similar charge.

"(b) LIMITATIONS ON EXERCISE OF AUTHORITY.—

"(1) INDIVIDUALS WITH FAMILY INCOME BELOW 100 PERCENT OF POVERTY LEVEL.—In the case of an individual whose family income does not exceed 100 percent of the Federal poverty level applicable to a family of the size involved, subject to subsections (c)(2)(B) and (e)(2)(B), the limitations otherwise provided under subsections (a) and (b) of section 1916 shall continue to apply and no enrollment fee, premium, or similar charge will be imposed under the plan, except that the total annual aggregate amount of cost-sharing imposed (including any increase cost-sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved for the year involved.

"(2) INDIVIDUALS WITH FAMILY INCOME ABOVE 100 PERCENT OF POVERTY LEVEL.—In the case of an individual whose family income exceeds

100 percent of the Federal poverty level applicable to a family of the size involved, the total annual aggregate amount of premiums and cost-sharing imposed (including any increase cost-sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved for the year involved.

"(3) ADDITIONAL LIMITATIONS.—Subject to subsections the succeeding provisions of this section, no cost-sharing shall be imposed under this section with respect to the following:

"(A) Services furnished to individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including services furnished to individuals with respect to whom adoption or foster care assistance is made available under part E of title IV without regard to age.

"(B) Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income.

"(C) Services furnished to pregnant women, if such services relate to the pregnancy

or to any other medical condition which may complicate the pregnancy.

"(D) Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1905(o)).

"(E) Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

"(F) Emergency services (as defined by the Secretary for purposes of section 1916(a)(2)(D)).

"(G) Family planning services and supplies described in section 1905(a)(4)(C).

Nothing in this paragraph shall be construed as preventing a State from exempting additional classes of individuals or services from cost-sharing under this section.

"(4) INDEXING NOMINAL AMOUNTS.—In applying section 1916 under paragraph (1) with respect to cost-sharing that is 'nominal' in amount—

"(A) the Secretary shall phase-in an increase in such amount over a 3 year period (beginning January 1, 2006) so that—

"(i) a $3 nominal amount in 2005 would be increased to be a $5 nominal amount in 2008; and

"(ii) other nominal amounts would be increased by a proportional amount (with appropriate rounding) during such period; and

"(B) the Secretary shall increase such 'nominal' amounts for each subsequent year (beginning with 2009) by the annual percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) as rounded up in an appropriate manner.

"(6) DETERMINATIONS OF FAMILY INCOME.—In applying this subsection, family income shall be determined in a manner specified by the State for purposes of this subsection, including the use of such disregards as the State may provide. Family in-

come shall be determined for such period and at such periodicity as the State may provide under this title.

"(7) POVERTY LINE DEFINED.—For purposes of this subsection, the term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

"(8) CONSTRUCTION.—Nothing in this section shall be construed—

"(A) as preventing a State from further limiting the premiums and cost-sharing imposed under this section beyond the limitations provided under this subsection;

"(B) as affecting the authority of the Secretary through waiver to modify limitations on premiums and cost-sharing under this subsection; or

"(C) as affecting any such waiver of requirements in effect under this title before the date of the enactment of this section with regard to the imposition of premiums and cost-sharing.

"(d) ENFORCEABILITY OF PREMIUMS AND OTHER COST-SHARING.—

"(1) PREMIUMS.—Notwithstanding section 1916(c)(3) and section 1902(a)(10)(B), a State may, at its option, condition the provision of medical assistance for an individual upon prepayment of a premium authorized to be imposed under this section, or may terminate eligibility for such medical assistance on the basis of failure to pay such a premium but shall not terminate eligibility of an individual for medical assistance under this title on the basis of failure to pay any such premium until such failure continues for a period of not less than 60 days. A State may apply the previous sentence for some or all groups of beneficiaries as specified by the State and may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

"(2) COST-SHARING.—Notwithstanding section 1916(e) or any other provision of law, a State may permit a provider participating under the State plan to require, as a condition for the provision of care, items, or services to an individual entitled to medical assistance under this title for such care, items, or

services, the payment of any cost-sharing authorized to be imposed under this section with respect to such care, items, or services. Nothing in this paragraph shall be construed as preventing a provider from reducing or waiving the application of such cost-sharing.".

(b) CONFORMING AMENDMENT.—Section 1916(f) of such Act (42 U.S.C. 1396o(f)) is amended by inserting "and section 1916A" after "(b)(3)".

(c) GAO STUDY OF IMPACT OF PREMIUMS AND COST-SHARING.—The Comptroller General of the United States shall conduct a study of the impact of premiums and cost-sharing under the medicaid program on access to, and utilization of, services. Not later than January 1, 2008, the Comptroller General shall submit a report to the Congress on such study.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to cost-sharing imposed for items and services furnished on or after January 1, 2006.

SEC. 3122. SPECIAL RULES FOR COST-SHARING FOR PRESCRIPTION DRUGS.

(a) IN GENERAL.—Section 1916A of the Social Security Act, as inserted by section 3121, is amended by inserting after subsection (b) the following new subsection:

"(c) SPECIAL RULES FOR COST-SHARING FOR PRESCRIPTION DRUGS.—

"(1) IN GENERAL.—In order to encourage beneficiaries to use drugs (in this subsection referred to as 'preferred drugs') identified by the State as the least (or less) costly effective prescription drugs within a class of drugs (as defined by the State), with respect to one or more groups of beneficiaries specified by the State, subject to paragraphs (2) and (5), the State may—

"(A) may provide an increase in cost-sharing (above the nominal level otherwise permitted under section 1916 or subsection (b), but subject to paragraphs (2) and (3)) for any beneficiary with respect to drugs that are not preferred drugs within a class; and

"(B) waive or reduce the cost-sharing otherwise applicable for preferred drugs within such class and shall not apply any such cost-sharing for such preferred drugs for individuals for whom cost-sharing may not otherwise be imposed under subsection (b)(3).

"(2) LIMITATIONS.—

"(A) BY INCOME GROUP AS A MULTIPLE OF NOMINAL AMOUNTS.—In no case may the

increase in cost-sharing under paragraph (1)(A) with respect to a non-preferred drug exceed, in the case of an individual whose family income is—

"(i) below 100 percent of the poverty line applicable to a family of the size involved, the amount of nominal cost sharing (as otherwise determined under subsection (b));

"(ii) at least 100 percent, but below 150 percent, of the poverty line applicable to a family of the size involved, two times the amount of nominal cost sharing (as otherwise determined under subsection (b)); or

"(iii) at least 150 percent of the poverty line applicable to a family of the size involved, three times the amount of nominal cost sharing (as otherwise determined under subsection (b)).

"(B) LIMITATION TO NOMINAL FOR EXEMPT POPULATIONS.—In the case of an individual who is otherwise not subject to cost-sharing due to the application of subsection (b)(3), any increase in cost-sharing under paragraph

(1)(A) with respect to a non-preferred drug may not exceed a nominal amount (as otherwise determined under subsection (b)).

"(C) CONTINUED APPLICATION OF AGGREGATE CAP.—In addition to the limitations imposed under subparagraphs (A) and (B), any increase in cost-sharing under paragraph (1)(A) continues to be subject to the aggregate cap on cost sharing applied under paragraph (1) or (2) of subsection (b), as the case may be.

"(D) TRICARE PHARMACY BENEFIT PROGRAM LIMITATIONS.—In no case may a State—

"(i) treat as a non-preferred drug under this subsection a drug that is treated as a preferred drug under the TRICARE pharmacy benefit program established under section 1074g of title 10, United States Code, as such program is in effect on the date of the enactment of this section ; or

"(ii) impose cost sharing under this subsection that exceeds the cost sharing imposed under the standards under such pharmacy benefit program, as such pro-

gram is in effect as of the date of the enactment of this section.

"(3) WAIVER.—In carrying out paragraph (1), a State shall provide for the application of cost-sharing levels applicable to a preferred drug in the case of a drug that is not a preferred drug if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both.

"(4) EXCLUSION AUTHORITY.—Nothing in this subsection shall be construed as preventing a State from excluding from paragraph (1) specified drugs or classes of drugs.

"(5) PRIOR AUTHORIZATION AND APPEALS PROCESS.—A State may not provide for increased cost-sharing under this subsection unless the State has implemented for outpatient prescription drugs a system for prior authorization and an appeals process for determinations relating to prior authorization.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to cost-sharing imposed for items and services furnished on or after October 1, 2006.

SEC. 3123. EMERGENCY ROOM COPAYMENTS FOR NON-EMERGENCY CARE.

(a) IN GENERAL.—Section 1916A of the Social Security Act, as inserted by section 3121 and as amended by section 3122, is further amended by adding at the end the following new subsection:

"(e) STATE OPTION FOR IMPOSING COST-SHARING FOR NON-EMERGENCY CARE FURNISHED IN AN HOSPITAL EMERGENCY ROOM.—

"(1) IN GENERAL.—Notwithstanding section 1916 or the previous provisions of this section, but subject to the limitations of paragraph (2), a State may, by amendment to its State plan under this title, impose cost-sharing for non-emergency services furnished to an individual (within one or more groups of individuals specified by the State) in a hospital emergency department under this subsection if the following conditions are met:

"(A) ACCESS TO NON-EMERGENCY ROOM PROVIDER.—The individual has actually available and accessible (as such terms are applied by the Secretary under section 1916(b)(3)) to an alternate non-emergency services provider with respect to such services.

"(B) NOTICE.—The physician or hospital must inform the beneficiary after the appro-

priate screening assessment, but before providing the non-emergency services, of the following:

"(i) The hospital may require the payment of the State specified cost-sharing before the service can be provided.

"(ii) The name and location of an alternate non-emergency services provider (described in subparagraph (A)) that is actually available and accessible (as described in such subparagraph).

"(iii) The fact that such alternate provider can provide the services without the imposition of the increase in cost-sharing described in clause (i).

"(iv) The hospital provides a referral to coordinate scheduling of this treatment.

Nothing in this subsection shall be construed as preventing a State from applying (or waiving) cost-sharing otherwise permissible under this section to services described in clause (iii).

"(2) LIMITATIONS.—

"(A) FOR POOREST BENEFICIARIES.—In the case of an individual described in subsection (b)(1), the cost-sharing imposed under this sub-

section may not exceed twice the amount determined to be nominal under this section, subject to the percent of income limitation otherwise applicable under subsection (b)(1).

"(B) APPLICATION TO EXEMPT POPULATIONS.—In the case of an individual who is otherwise not subject to cost-sharing under subsection (b)(3), a State may impose cost-sharing under paragraph (1) for care in an amount that does not exceed a nominal amount (as otherwise determined under subsection (b)) so long as no cost-sharing is imposed to receive such care through an outpatient department or other alternative health care provider in the geographic area of the hospital emergency department involved.

"(C) CONTINUED APPLICATION OF AGGREGATE CAP.—In addition to the limitations imposed under subparagraphs (A) and (B), any increase in cost-sharing under paragraph (1) continues to be subject to the aggregate cap on cost sharing applied under paragraph (1) or (2) of subsection (b), as the case may be.

"(3) CONSTRUCTION.—Nothing in this section shall be construed—

"(A) to limit a hospital's obligations with respect to screening and stabilizing treatment of an emergency medical condition under section 1867; or

"(B) to modify any obligations under either State or Federal standards relating to the application of a prudent-layperson standard with respect to payment or coverage of emergency services by any managed care organization.

"(4) DETERMINATION STANDARD.—No hospital or physician that makes a determination with respect to the imposition of cost-sharing under this subsection shall be liable in any civil action or proceeding for such determination absent a finding by clear and convincing evidence of gross negligence by the hospital or physician. The previous sentence shall not affect any liability under section 1867 or otherwise applicable under State law based upon the provision (or failure to provide) care.

"(5) DEFINITIONS.—For purposes of this subsection:

"(A) NON-EMERGENCY SERVICES.—The term 'non-emergency services' means any care or services furnished in a emergency depart-

ment of a hospital that the physician determines do not constitute an appropriate medical screening examination or stabilizing examination and treatment screening required to be provided by the hospital under section 1867.

"(B) ALTERNATE NON-EMERGENCY SERVICES PROVIDER.—The term 'alternative non-emergency services provider' means, with respect to non-emergency services for the diagnosis or treatment of a condition, a health care provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar health care provider, that provides clinically appropriate services for such diagnosis or treatment of the condition within a clinically appropriate time of the provision of such non-emergency services and that is participating in the program under this title.".

(b) GRANT FUNDS FOR ESTABLISHMENT OF ALTERNATE NON-EMERGENCY SERVICES PROVIDERS.—Section 1903 of the Social Security Act (42 U.S.C. 1396b), as amended by section 3104, is further amended by adding at the end the following new subsection:

"(y) PAYMENTS FOR ESTABLISHMENT OF ALTERNATE NON-EMERGENCY SERVICES PROVIDERS.—

"(1) PAYMENTS.—In addition to the payments otherwise provided under subsection (a), subject to paragraph (2), the Secretary shall provide for payments to States under such subsection for the establishment of alternate non-emergency service providers (as defined in section 1916A(f)(6)(B)), or networks of such providers.

"(2) LIMITATION.—The total amount of payments under this subsection shall be equal to, and shall not exceed, $100,000,000 during the four-year period beginning with 2006. This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

"(3) PREFERENCE.—In providing for payments to States under this subsection, the Secretary shall provide preference to States that establish, or provide for, alternate non-emergency services providers or networks of such providers that—

"(A) serve rural or underserved areas where beneficiaries under this title may not

have regular access to providers of primary care services; or

"(B) are in partnership with local community hospitals.

"(4) FORM AND MANNER OF PAYMENT.—Payment to a State under this subsection shall be made only upon the filing of such application in such form and in such manner as the Secretary shall specify. Payment to a State under this subsection shall be made in the same manner as other payments under section 1903(a).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to non-emergency services furnished on or after the date of the enactment of this Act.

SEC. 3124. USE OF BENCHMARK BENEFIT PACKAGES.

Title XIX of the Social Security Act is amended by redesignating section 1936 as section 1937 and by inserting after section 1935 the following new section:

"STATE FLEXIBILITY IN BENEFIT PACKAGES

"SEC. 1936. (a) STATE OPTION OF PROVIDING BENCHMARK BENEFITS.—

"(1) AUTHORITY.—

"(A) IN GENERAL.—Notwithstanding any other provision of this title, a State, at its option as a State plan amendment, may provide for medical assistance under this title to indi-

viduals within one or more groups of individuals specified by the State through enrollment in coverage that provides—

"(i) benchmark coverage described in subsection (b)(1); or

"(ii) benchmark equivalent coverage described in subsection (b)(2).

"(B) OPTION OF WRAP-AROUND BENEFITS.—In the case of coverage described in subparagraph (A), a State, at its option, may provide such wrap-around or additional benefits as the State may specify.

"(C) TREATMENT AS MEDICAL ASSISTANCE.—Payment of premiums for such coverage under this subsection shall be treated as payment of other insurance premiums described in the third sentence of section 1905(a).

"(2) APPLICATION.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), a State may require that a full-benefit eligible individual (as defined in subparagraph (C)) within a group obtain benefits under this title through enrollment in coverage described in paragraph (1)(A). A State

may apply the previous sentence to individuals within one or more groups of such individuals.

"(B) LIMITATION ON APPLICATION.—A State may not require under subparagraph (A) an individual to obtain benefits through enrollment described in paragraph (1)(A) if the individual is within one of the following categories of individuals:

"(i) MANDATORY PREGNANT WOMEN AND CHILDREN.—The individual is a pregnant woman or child under 18 years of age who is required to be covered under the State plan under section 1902(a)(10)(A)(i).

"(ii) DUAL ELIGIBLES.—The individual is entitled to benefits under any part of title XVIII.

"(iii) TERMINALLY ILL HOSPICE PATIENTS.—The individual is terminally ill and is receiving benefits for hospice care under this title.

"(iv) ELIGIBLE ON BASIS OF INSTITUTIONALIZATION.—The individual is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally re-

tarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

"(v) MEDICALLY FRAIL AND SPECIAL MEDICAL NEEDS INDIVIDUALS.—The individual is medically frail or otherwise an individual with special medical needs (as identified in accordance with regulations of the Secretary).

"(vi) BENEFICIARIES QUALIFYING FOR LONG-TERM CARE SERVICES.—The individual qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C).

"(C) FULL-BENEFIT ELIGIBLE INDIVIDUALS.—

"(i) IN GENERAL.—For purposes of this paragraph, subject to clause (ii), the term 'full-benefit eligible individual' means for a State for a month an individual who

is determined eligible by the State for medical assistance for all services defined in section 1905(a) which are covered under the State plan under this title for such month under section 1902(a)(10)(A) or under any other category of eligibility for medical assistance for all such services under this title, as determined by the Secretary.

"(ii) EXCLUSION OF MEDICALLY NEEDY AND SPEND-DOWN POPULATIONS.—Such term shall not include an individual determined to be eligible by the State for medical assistance under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise eligible based on a reduction of income based on costs incurred for medical or other remedial care.

"(b) BENCHMARK BENEFIT PACKAGES.—

"(1) IN GENERAL.—For purposes of subsection (a)(1), each of the following coverage shall be considered to be benchmark coverage:

"(A) FEHBP-EQUIVALENT HEALTH INSURANCE COVERAGE.—The standard Blue Cross/Blue Shield preferred provider option

service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

"(B) STATE EMPLOYEE COVERAGE.—A health benefits coverage plan that is offered and generally available to State employees in the State involved.

"(C) COVERAGE OFFERED THROUGH HMO.—The health insurance coverage plan that—

"(i) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act), and

"(ii) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

"(2) BENCHMARK-EQUIVALENT COVERAGE.—For purposes of subsection (a)(1), coverage that meets the following requirement shall be considered to be benchmark-equivalent coverage:

"(A) INCLUSION OF BASIC SERVICES.—The coverage includes benefits for items and

services within each of the following categories of basic services:

"(i) Inpatient and outpatient hospital services.

"(ii) Physicians' surgical and medical services.

"(iii) Laboratory and x-ray services.

"(iv) Well-baby and well-child care, including age-appropriate immunizations.

"(v) Other appropriate preventive services, as designated by the Secretary.

"(B) AGGREGATE ACTUARIAL VALUE EQUIVALENT TO BENCHMARK PACKAGE.—The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages described in paragraph (1).

"(C) SUBSTANTIAL ACTUARIAL VALUE FOR ADDITIONAL SERVICES INCLUDED IN BENCHMARK PACKAGE.—With respect to each of the following categories of additional services for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial

value of the coverage of that category of services in such package:

"(i) Coverage of prescription drugs.

"(ii) Mental health services.

"(iii) Vision services.

"(iv) Hearing services.

"(3) DETERMINATION OF ACTUARIAL VALUE.—The actuarial value of coverage of benchmark benefit packages shall be set forth in an actuarial opinion in an actuarial report that has been prepared—

"(A) by an individual who is a member of the American Academy of Actuaries;

"(B) using generally accepted actuarial principles and methodologies;

"(C) using a standardized set of utilization and price factors;

"(D) using a standardized population that is representative of the population involved;

"(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

"(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

"(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under this title that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).".

SEC. 3125. STATE OPTION TO ESTABLISH NON-EMERGENCY MEDICAL TRANSPORTATION PROGRAM.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (66), by striking "and" at the end;

(2) in paragraph (67) by striking the period at the end and inserting "; and"; and

(3) by inserting after paragraph (67) the following:

"(68) at the option of the State and notwithstanding paragraph (10)(B) or (23), provide for the establishment of a non-emergency medical transportation program in order to more cost-effectively provide transportation for individuals eligible for med-

ical assistance under the State plan who need access to medical care or services and have no other means of transportation which—

"(A) may include wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation, and such other transportation as the Secretary determines appropriate; and

"(B) may be conducted under contract with a broker who—

"(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;

"(ii) has oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified, competent, and courteous;

"(iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services; and

"(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on the prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate).".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on the date of the enactment of this Act.

(c) IG REPORT ON UTILIZATION.—Not later than January 1, 2007, the Inspector General of the Department of Health and Human Services shall submit to Congress a report that examines the non-emergency medical transportation programs implemented under section 1902(a)(68) of the Social Security Act, as inserted by subsection (a). The report shall include findings regarding conflicts of interest and improper utilization of transportation services under such programs, as well as recommendations for improvements in such programs.

CHAPTER 4—EXPANDED ACCESS TO CERTAIN BENEFITS

SEC. 3131. EXPANDED ACCESS TO HOME AND COMMUNITY-BASED SERVICES FOR THE ELDERLY AND DISABLED.

(a) IN GENERAL.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended—

(1) in paragraph (27), by striking "and" at the end;

(2) by redesignating paragraph (28) as paragraph (29); and

(3) by inserting after paragraph (27) the following new paragraph:

"(28) subject to section 1902(cc), home and community-based services (within the scope of services described in paragraph (4)(B) of section 1915(c) for which the Secretary has the authority to approve a waiver and not including room and board) provided pursuant to a written plan or care for individuals—

"(A) who are 65 years or age or older or who are disabled (as defined under the State plan), but who are not individuals with developmental disabilities or mentally retarded or persons with related conditions;

"(B) with respect to whom there has been a determination, in the manner described in paragraph (1) of such section, that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility the cost of which could be reimbursed under the State plan; and

"(C) who qualify for medical assistance under the eligibility standards in effect in the State (which may include standards in effect under an approved waiver) as of the date of the enactment of this paragraph; and".

(b) CONDITIONS.—Section 1902 of such Act (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

"(cc) PROVISION OF HOME AND COMMUNITY-BASED SERVICES UNDER STATE PLAN.—

"(1) CONDITIONS.—A State may provide home and community-based services under section 1905(a)(28), other than through a waiver or demonstration project under section 1915 or 1115, only if the following conditions are met:

"(A) EXPIRATION OF PREVIOUS WAIVER.—Any State waiver or demonstration project under either such section with respect to serv-

ices for individuals described in such section has expired.

"(B) INFORMATION.—The State must monitor and report to the Secretary, in a form and manner specified by the Secretary and on a quarterly basis, enrollment and expenditures for provision of such services under such section.

"(2) OPTIONS.—Notwithstanding any other provision of this title, in a State's provision of services under section 1905(a)(28)—

"(A) a State is not required to comply with the requirements of section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community);

"(B) a State may limit the number of individuals who are eligible for such services and may establish waiting lists for the receipt of such services; and

"(C) a State may limit the amount, duration, and scope of such services.

Nothing in this section shall be construed as applying the previous sentence of any items or services

other than home and community-based services provided under section 1905(a)(28).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to home and community-based services furnished on or after October 1, 2006.

SEC. 3132. OPTIONAL CHOICE OF SELF-DIRECTED PERSONAL ASSISTANCE SERVICES (CASH AND COUNSELING).

(a) EXEMPTION FROM CERTAIN REQUIREMENTS.—Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following new sub-section:

"(i)(1) A State may provide, as 'medical assistance', payment for part or all of the cost of self-directed personal assistance services (other than room and board) under the plan which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under the plan, or home and community-based services provided pursuant to a waiver under sub-section (c). Self-directed personal assistance services may not be provided under this subsection to individuals who reside in a home or property that is owned, operated, or con-

trolled by a provider of services, not related by blood or marriage.

"(2) The Secretary shall not grant approval for a State self-directed personal assistance services program under this section unless the State provides assurances satisfactory to the Secretary of the following:

"(A) Necessary safeguards have been taken to protect the health and welfare of individuals provided services under the program, and to assure financial accountability for funds expended with respect to such services.

"(B) The State will provide, with respect to individuals who—

"(i) are entitled to medical assistance for personal care services under the plan, or receive home and community-based services under a waiver granted under subsection (c);

"(ii) may require self-directed personal assistance services; and

"(iii) may be eligible for self-directed personal assistance services,

an evaluation of the need for personal care under the plan, or personal services under a waiver granted under subsection (c).

"(C) Such individuals who are determined to be likely to require personal care under the plan, or home and community-based services under a waiver granted under subsection (c) are informed of the feasible alternatives, if available under the State's self-directed personal assistance services program, at the choice of such individuals, to the provision of personal care services under the plan, or personal assistance services under a waiver granted under subsection (c).

"(D) The State will provide for a support system that ensures participants in the self-directed personal assistance services program are appropriately assessed and counseled prior to enrollment and are able to manage their budgets. Additional counseling and management support may be provided at the request of the participant.

"(E) The State will provide to the Secretary an annual report on the number of individuals served and total expenditures on their behalf in the aggregate. The State shall also provide an evaluation of overall impact on the health and welfare of participating individuals compared to non-participants every three years.

"(3) A State may provide self-directed personal assistance services under the State plan without regard to the requirements of section 1902(a)(1) and may limit the population eligible to receive these services and limit the number of persons served without regard to section 1902(a)(10)(B).

"(4)(A) For purposes of this subsection, the term 'self-directed personal assistance services' means personal care and related services, or home and community-based services otherwise available under the plan under this title or subsection (c), that are provided to an eligible participant under a self-directed personal assistance services program under this section, under which individuals, within an approved self-directed services plan and budget, purchase personal assistance and related services, and permits participants to hire, fire, supervise, and manage the individuals providing such services.

"(B) At the election of the State—

"(i) a participant may choose to use any individual capable of providing the assigned tasks including legally liable relatives as paid providers of the services; and

"(ii) the individual may use the individual's budget to acquire items that increase independence or substitute (such as a microwave oven or an acces-

sibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

"(5) For purpose of this section, the term 'approved self-directed services plan and budget' means, with respect to a participant, the establishment of a plan and budget for the provision of self-directed personal assistance services, consistent with the following requirements:

"(A) SELF-DIRECTION.—The participant (or in the case of a participant who is a minor child, the participant's parent or guardian, or in the case of an incapacitated adult, another individual recognized by state law to act on behalf of the participant) exercises choice and control over the budget, planning, and purchase of self-directed personal assistance services, including the amount, duration, scope, provider and location of service provision.

"(B) ASSESSMENT OF NEEDS.—There is an assessment of the needs, strengths, and preferences of the participants for such services.

"(C) SERVICE PLAN.—A plan for such services (and supports for such services) for the participant has been developed and approved by the State based on such assessment through a person-centered process that—

"(i) builds upon the participant's capacity to engage in activities that promote community life and that respects the participant's preferences, choices and abilities; and

"(ii) involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the participant.

"(D) SERVICE BUDGET.—A budget for such services and supports for the participant has been developed and approved by the State based on such assessment and plan and on a methodology that uses valid, reliable cost data, is open to public inspection, and includes a calculation of the expected cost of such services if those services were not self-directed. The budget may not restrict access to other medically necessary care and services furnished under the plan and approved by the state but not included in the budget.

"(E) APPLICATION OF QUALITY ASSURANCE AND RISK MANAGEMENT.—There are appropriate quality assurance and risk management techniques used in establishing and implementing such plan and budget that recognize the roles and responsibilities in obtaining services in a self-directed manner and

assure the appropriateness of such plan and budget based upon the participant's resources and capabilities.

"(6) A State may employ a financial management entity to make payments to providers, track costs, and make reports under the program. Payment for the activities of the financial management entity shall be at the administrative rate established in section 1903(a).".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 2006.

SEC. 3133. EXPANSION OF STATE LONG-TERM CARE PARTNERSHIP PROGRAM.

(a) IN GENERAL.—Section 1917(b) of the Social Security Act (42 U.S.C. 1396p(b)) is amended—

(1) in paragraph (1)(C)(ii), by inserting "or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii))" after "1993,"; and

(2) by adding at the end of paragraph (1)(C) the following new clauses:

"(iii) For purposes of this paragraph, the term 'qualified State long-term care insurance partnership' means an approved State plan amendment under this title that provides for the disregard of

any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy (including a certificate issued under a group insurance contract), if the following requirements are met:

"(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

"(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986) issued on or after the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary.

"(III) If the policy does not provide some level of inflation protection, the insured was offered, before the policy was sold, a long-term care insurance policy that provides some level of inflation protection.

"(IV) The State Medicaid agency under section 1902(a)(5) provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-

term care insurance policy under the partnership receives training or demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

"(V) The issuer of the policy provides regular reports to the Secretary that include, in accordance with regulations of the Secretary (promulgated after consultation with the States), notification regarding when all benefits provided under the policy have been paid and the amount of such benefits paid, when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

"(VI) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, sub-

clause (I) shall be applied based on the coverage of the first such policy that was exchanged.

"(iv) The Secretary—

"(I) as appropriate, shall provide copies of the reports described in clause (iii)(V) to the State involved; and

"(II) shall promote the education of consumers regarding qualified State long-term care insurance partnerships.

"(v) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, and State insurance commissioners, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report generating mechanism that State, the Secretary, and other Federal agencies can access.".

(b) CONSTRUCTION.—Nothing in the amendments made by subsection (a) shall be construed as affecting the treatment of long-term care insurance policies that will be, are, or were provided under a State plan amendment de-

scribed in section 1917(b)(1)(C)(ii) of the Social Security Act that was approved as of May 14, 1993.

(c) EFFECTIVE DATE.—A State plan amendment that provides for a qualified State long-term care insurance partnership under the amendments made by subsection (a) may provide that such amendment is effective for long-term care insurance policies issued on or after a date, specified in the amendment, that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary of Health and Human Services.

(d) STANDARDS FOR RECIPROCAL RECOGNITION AMONG PARTNERSHIP STATES.—In order to permit portability in long-term care insurance policies purchased under State long-term care insurance partnerships, the Secretary may develop, in consultation with the States and the National Association of Insurance Commissioners, uniform standards for reciprocal recognition of such policies among States with qualified State long-term care insurance partnerships.

SEC. 3134. HEALTH OPPORTUNITY ACCOUNTS.

Title XIX of the Social Security Act, as amended by section 3124, is amended—

(1) by redesignating section 1937 as section 1938; and

(2) by inserting after section 1936 the following new section:

"HEALTH OPPORTUNITY ACCOUNTS

"SEC. 1937. (a) AUTHORITY.—

"(1) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary shall establish a demonstration program under which States may provide under their State plans under this title (including such a plan operating under a statewide waiver under section 1115) in accordance with this section for the provision of alternative benefits consistent with subsection (c) for eligible population groups in one or more geographic areas of the State specified by the State. An amendment under the previous sentence is referred to in this section as a 'State demonstration program'.

"(2) INITIAL DEMONSTRATION.—The demonstration program under this section shall begin on January 1, 2006. During the first 5 years of such program, the Secretary shall not approve more than 10 State demonstration programs, with each State demonstration program covering one or more geographic areas specified by the State. After such 5-year period—

"(A) unless the Secretary finds, taking into account cost-effectiveness, quality of care,

and other criteria that the Secretary specifies, that a State demonstration program previously implemented has been unsuccessful, such a demonstration program may be extended or made permanent in the State; and

"(B) unless the Secretary finds, taking into account cost-effectiveness, quality of care, and other criteria that the Secretary specifies, that all State demonstration program previously implemented were unsuccessful, other States may implement State demonstration programs.

"(3) APPROVAL.—The Secretary shall not approve a State demonstration program under paragraph (1) unless the program includes the following:

"(A) Creating patient awareness of the high cost of medical care.

"(B) Providing incentives to patients to seek preventive care services.

"(C) Reducing inappropriate use of health care services.

"(D) Enabling patients to take responsibility for health outcomes.

"(E) Providing enrollment counselors and ongoing education activities.

"(F) Providing transactions involving health opportunity accounts to be conducted electronically and without cash.

"(G) Providing access to negotiated provider payment rates consistent with this section.

Nothing in this section shall be construed as preventing a State demonstration program from providing incentives for patients obtaining appropriate preventive care (as defined for purposes of section 223(c)(2)(C) of the Internal Revenue Code of 1986), such as additional account contributions for an individual demonstrating healthy prevention practices.

"(4) NO REQUIREMENT FOR STATEWIDENESS.—Nothing in this section or any other provision of law shall be construed to require that a State must provide for the implementation of a State demonstration program on a Statewide basis.

"(5) REPORTS.—The Secretary shall periodically submit to Congress reports regarding the success of State demonstration programs.

"(b) ELIGIBLE POPULATION GROUPS.—

"(1) IN GENERAL.—A State demonstration program under this section shall specify the eligible

population groups consistent with paragraphs (2) and (3).

"(2) ELIGIBILITY LIMITATIONS DURING INITIAL DEMONSTRATION PERIOD.—During the initial 5 years of the demonstration program under this section, a State demonstration project shall not apply to any of the following individuals:

"(A) Individuals who are 65 years of age or older.

"(B) Individuals who are disabled, regardless of whether or not their eligibility for medical assistance under this title is based on such disability.

"(C) Individuals who are eligible for medical assistance under this title only because they are (or were within previous 60 days) pregnant.

"(D) Individuals who have been eligible for medical assistance for a continuous period of less than 3 months.

"(3) ADDITIONAL LIMITATIONS.—A State demonstration project shall not apply to any individual within a category of individual described in section 1936(a)(2)(B).

"(4) LIMITATIONS.—

"(A) STATE OPTION.—This subsection shall not be construed as preventing a State from further limiting eligibility.

"(B) ON ENROLLEES IN MEDICAID MANAGED CARE ORGANIZATIONS.—Insofar as the State provides for eligibility of individuals who are enrolled in medicaid managed care organizations, such individuals may participate in the State demonstration project only if the State provides assurances satisfactory to the Secretary that the following conditions are met with respect to any such organization:

"(i) In no case may the number of such individuals enrolled in the organization who participate in the project exceed 5 percent of the total number of individuals enrolled in such organization.

"(ii) The proportion of enrollees in the organization who so participate is not significantly disproportionate to the proportion of such enrollees in other such organizations who participate.

"(iii) The State has provided for an appropriate adjustment in the per capita payments to the organization to account

for such participation, taking into account differences in the likely use of health services between enrollees who so participate and enrollees who do not so participate.

"(5) VOLUNTARY PARTICIPATION.—An eligible individual shall be enrolled in a State demonstration project only if the individual voluntarily enrolls. Except in such hardship cases as the Secretary shall specify, such an enrollment shall be effective for a period of 12 months, but may be extended for additional periods of 12 months each with the consent of the individual.

"(c) ALTERNATIVE BENEFITS.—

"(1) IN GENERAL.—The alternative benefits provided under this section shall consist, consistent with this subsection, of at least—

"(A) coverage for medical expenses in a year for items and services for which benefits are otherwise provided under this title after an annual deductible described in paragraph (2) has been met; and

"(B) contribution into a health opportunity account.

Nothing in subparagraph (A) shall be construed as preventing a State from providing for coverage of

preventive care (referred to in subsection (a)(3)) within the alternative benefits without regard to the annual deductible.

"(2) ANNUAL DEDUCTIBLE.—The amount of the annual deductible described in paragraph (1)(A) shall be at least 100 percent, but no more than 110 percent, of the annualized amount of contributions to the health opportunity account under subsection (d)(2)(A)(i), determined without regard to any limitation described in subsection (d)(2)(C)(ii).

"(3) ACCESS TO NEGOTIATED PROVIDER PAYMENT RATES.—

"(A) FEE-FOR-SERVICE ENROLLEES.—In the case of an individual who is participating in a State demonstration project and who is not enrolled with a medicaid managed care organization, the State shall provide that the individual may obtain demonstration project medicaid services from—

"(i) any participating provider under this title at the same payment rates that would be applicable to such services if the deductible described in paragraph (1)(A) was not applicable; or

"(ii) any provider at payment rates that do not exceed 125 percent of the payment rate that would be applicable to such services furnished by a participating provider under this title if the deductible described in paragraph (1)(A) was not applicable.

"(B) TREATMENT UNDER MEDICAID MANAGED CARE PLANS.—In the case of an individual who is participating in a State demonstration project and is enrolled with a medicaid managed care organization, the State shall enter into an arrangement with the organization under which the individual may obtain demonstration project medicaid services from any provider under such organization at payment rates that do not exceed the payment rate that would be applicable to such services if the deductible described in paragraph (1)(A) was not applicable.

"(C) COMPUTATION.—The payment rates described in subparagraphs (A) and (B) shall be computed without regard to any cost-sharing that would be otherwise applicable under section 1916.

"(D) DEFINITIONS.—For purposes of this paragraph:

"(i) The term 'demonstration project medicaid services' means, with respect to an individual participating in a State demonstration project, services for which the individual would be provided medical assistance under this title but for the application of the deductible described in paragraph (1)(A).

"(ii) The term 'participating provider' means—

"(I) with respect to an individual described in subparagraph (A), a health care provider that has entered into a participation agreement with the State for the provision of services to individuals entitled to benefits under the State plan; or

"(II) with respect to an individual described in subparagraph (B) who is enrolled in a medicaid managed care organization, a health care provider that has entered into an arrangement for the provision of serv-

ices to enrollees of the organization under this title.

"(4) NO EFFECT ON SUBSEQUENT BENEFITS.—Except as provided under paragraphs (1) and (2), alternative benefits for an eligible individual shall consist of the benefits otherwise provided to the individual, including cost-sharing relating to such benefits.

"(5) OVERRIDING COST-SHARING AND COMPARABILITY REQUIREMENTS FOR ALTERNATIVE BENEFITS.—The provisions of this title relating to cost-sharing for benefits (including section 1916) shall not apply with respect to benefits to which the annual deductible under paragraph (1)(A) applies. The provisions of section 1902(a)(10)(B) (relating to comparability) shall not apply with respect to the provision of alternative benefits (as described in this subsection).

"(6) TREATMENT AS MEDICAL ASSISTANCE.—Subject to subparagraphs (D) and (E) of subsection (d)(2), payments for alternative benefits under this section (including contributions into a health opportunity account) shall be treated as medical assistance for purposes of section 1903(a).

"(7) USE OF TIERED DEDUCTIBLE AND COST-SHARING.—

"(A) IN GENERAL.—A State—

"(i) may vary the amount of the annual deductible applied under paragraph (1)(A) based on the income of the family involved so long as it does not favor families with higher income over those with lower income; and

"(ii) may vary the amount of the maximum out-of-pocket cost-sharing (as defined in subparagraph (B)) based on the income of the family involved so long as it does not favor families with higher income over those with lower income.

"(B) MAXIMUM OUT-OF-POCKET COST-SHARING.—For purposes of subparagraph (A)(ii), the term 'maximum out-of-pocket cost-sharing' means, for an individual or family, the amount by which the annual deductible level applied under paragraph (1)(A) to the individual or family exceeds the balance in the health opportunity account for the individual or family.

"(8) CONTRIBUTIONS BY EMPLOYERS.—Nothing in this section shall be construed as preventing

an employer from providing health benefits coverage consisting of the coverage described in paragraph (1)(A) to individuals who are provided alternative benefits under this section.

"(d) HEALTH OPPORTUNITY ACCOUNT.—

"(1) IN GENERAL.—For purposes of this section, the term 'health opportunity account' means an account that meets the requirements of this subsection.

"(2) CONTRIBUTIONS.—

"(A) IN GENERAL.—No contribution may be made into a health opportunity account except—

"(i) contributions by the State under this title; and

"(ii) contributions by other persons and entities, such as charitable organizations.

"(B) STATE CONTRIBUTION.—A State shall specify the contribution amount that shall be deposited under subparagraph (A)(i) into a health opportunity account.

"(C) LIMITATION ON ANNUAL STATE CONTRIBUTION PROVIDED AND PERMITTING IMPOSITION OF MAXIMUM ACCOUNT BALANCE.—

"(i) IN GENERAL.—A State—

"(I) may impose limitations on the maximum contributions that may be deposited under subparagraph (A)(i) into a health opportunity account in a year;

"(II) may limit contributions into such an account once the balance in the account reaches a level specified by the State; and

"(III) subject to clauses (ii) and (iii) and subparagraph (D)(i), may not provide contributions described in subparagraph (A)(i) to a health opportunity account on behalf of an individual or family to the extent the amount of such contributions (including both State and Federal shares) exceeds, on an annual basis, $2,500 for each individual (or family member) who is an adult and $1,000 for each individual (or family member) who is a child.

"(ii) INDEXING OF DOLLAR LIMITATIONS.—For each year after 2006, the dol-

lar amounts specified in clause (i)(III) shall be annually increased by the Secretary by a percentage that reflects the annual percentage increase in the medical care component of the consumer price index for all urban consumers.

"(iii) BUDGET NEUTRAL ADJUSTMENT.—A State may provide for dollar limitations in excess of those specified in clause (i)(III) (as increased under clause (ii)) for specified individuals if the State provides assurances satisfactory to the Secretary that contributions otherwise made to other individuals will be reduced in a manner so as to provide for aggregate contributions that do not exceed the aggregate contributions that would otherwise be permitted under this subparagraph.

"(D) LIMITATIONS ON FEDERAL MATCHING.—

"(i) STATE CONTRIBUTION.—A State may contribute under subparagraph (A)(i) amounts to a health opportunity account in excess of the limitations provided under subparagraph (C)(i)(III), but no Federal

financial participation shall be provided under section 1903(a) with respect to contributions in excess of such limitations.

"(ii) NO FFP FOR PRIVATE CONTRIBUTIONS.—No Federal financial participation shall be provided under section 1903(a) with respect to any contributions described in subparagraph (A)(ii) to a health opportunity account.

"(E) APPLICATION OF DIFFERENT MATCHING RATES.—The Secretary shall provide a method under which, for expenditures made from a health opportunity account for medical care for which the Federal matching rate under section 1903(a) exceeds the Federal medical assistance percentage, a State may obtain payment under such section at such higher matching rate for such expenditures.

"(3) USE.—

"(A) GENERAL USES.—

"(i) IN GENERAL.—Subject to the succeeding provisions of this paragraph, amounts in a health opportunity account may be used for payment of such health care expenditures as the State specifies.

"(ii) GENERAL LIMITATION.—In no case shall such account be used for payment for health care expenditures that are not payment of medical care (as defined by section 213(d) of the Internal Revenue Code of 1986).

"(iii) STATE RESTRICTIONS.—In applying clause (i), a State may restrict payment for—

"(I) providers of items and services to providers that are licensed or otherwise authorized under State law to provide the item or service and may deny payment for such a provider on the basis that the provider has been found, whether with respect to this title or any other health benefit program, to have failed to meet quality standards or to have committed one or more acts of fraud or abuse; and

"(II) items and services insofar as the State finds they are not medically appropriate or necessary.

"(iv) ELECTRONIC WITHDRAWALS.—The State demonstration program shall

provide for a method whereby withdrawals may be made from the account for such purposes using an electronic system and shall not permit withdrawals from the account in cash.

"(B) MAINTENANCE OF HEALTH OPPORTUNITY ACCOUNT AFTER BECOMING INELIGIBLE FOR PUBLIC BENEFIT.—

"(i) IN GENERAL.—Notwithstanding any other provision of law, if an account holder of a health opportunity account becomes ineligible for benefits under this title because of an increase in income or assets—

"(I) no additional contribution shall be made into the account under paragraph (2)(A)(i);

"(II) subject to clause (iii), the balance in the account shall be reduced by 25 percent; and

"(III) subject to the succeeding provisions of this subparagraph, the account shall remain available to the account holder for withdrawals under the same terms and conditions as if

the account holder remained eligible for such benefits.

"(ii) SPECIAL RULES.—Withdrawals under this subparagraph from an account—

"(I) shall be available for the purchase of health insurance coverage; and

"(II) may, subject to clause (iv), be made available (at the option of the State) for such additional expenditures (such as job training and tuition expenses) specified by the State (and approved by the Secretary) as the State may specify.

"(iii) EXCEPTION FROM 25 PERCENT SAVINGS TO GOVERNMENT FOR PRIVATE CONTRIBUTIONS.—Clause (i)(II) shall not apply to the portion of the account that is attributable to contributions described in paragraph (2)(A)(ii). For purposes of accounting for such contributions, withdrawals from a health opportunity account shall first be attributed to contributions described in paragraph (2)(A)(i).

"(iv) CONDITION FOR NON-HEALTH WITHDRAWALS.—No withdrawal may be made from an account under clause (ii)(II) unless the accountholder has participated in the program under this section for at least 1 year.

"(v) NO REQUIREMENT FOR CONTINUATION OF COVERAGE.—An account holder of a health opportunity account, after becoming ineligible for medical assistance under this title, is not required to purchase high-deductible or other insurance as a condition of maintaining or using the account.

"(4) ADMINISTRATION.—A State may coordinate administration of health opportunity accounts through the use of a third party administrator and reasonable expenditures for the use of such administrator shall be reimbursable to the State in the same manner as other administrative expenditures under section 1903(a)(7).

"(5) TREATMENT.—Amounts in, or contributed to, a health opportunity account shall not be counted as income or assets for purposes of determining eligibility for benefits under this title.

"(6) UNAUTHORIZED WITHDRAWALS.—A State may establish procedures—

"(A) to penalize or remove an individual from the health opportunity account based on nonqualified withdrawals by the individual from such an account; and

"(B) to recoup costs that derive from such nonqualified withdrawals.".

CHAPTER 5—OTHER PROVISIONS

SEC. 3141. INCREASE IN MEDICAID PAYMENTS TO INSULAR AREAS.

Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(1) in paragraph (2), by inserting "and subject to paragraph (3)" after "subsection (f)"; and

(2) by adding at the end the following new paragraph:

"(3) FISCAL YEAR 2006 AND 2007 FOR CERTAIN INSULAR AREAS.—The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for fiscal year 2006 and fiscal year 2007 shall be increased by the following amounts:

"(A) For Puerto Rico, $12,000,000 for fiscal year 2006 and $12,000,000 for fiscal year 2007.

"(B) For the Virgin Islands, $2,500,000 for fiscal year 2006 and $5,000,000 for fiscal year 2007.

"(C) For Guam, $2,500,000 for fiscal year 2006 and $5,000,000 for fiscal year 2007.

"(D) For the Northern Mariana Islands, $1,000,000 for fiscal year 2006 and $2,000,000 for fiscal year 2007.

"(E) For American Samoa, $2,000,000 for fiscal year 2006 and $4,000,000 for fiscal year 2007.

Such amounts shall not be taken into account in applying paragraph (2) for fiscal year 2007 but shall be taken into account in applying such paragraph for fiscal year 2008 and subsequent fiscal years.".

SEC. 3142. MANAGED CARE ORGANIZATION PROVIDER TAX REFORM.

(a) IN GENERAL.—Section 1903(w)(7)(A)(viii) of the Social Security Act (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended to read as follows:

"(viii) Services of managed care organizations (including health maintenance organiza-

tions, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation).".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendment made by subsection (a) shall be effective as of the date of the enactment of this Act.

(2) GRANDFATHER.—

(A) IN GENERAL.—Subject to subparagraph (B), in the case of a State that has had approved as of the date of the enactment of this Act a provider tax on services described in section 1903(w)(7)(A)(viii) of the Social Security Act, as amended by subsection (a), such amendment shall be effective as of October 1, 2008.

(B) TRANSITION RULE FOR FISCAL YEAR 2009.—In the case of a State described in subparagraph (A), the amount of any reduction in payment under subsection (a)(1) of section 1903 of the Social Security Act (42 U.S.C. 1396b) that would otherwise be required under subsection (w) of such section because of the amendment made by section (a) shall be reduced by one-half.

SEC. 3143. MEDICAID TRANSFORMATION GRANTS.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b), as amended by section 3104, is amended by adding at the end the following new subsection:

"(y) MEDICAID TRANSFORMATION PAYMENTS.—

"(1) IN GENERAL.—In addition to the payments provided under subsection (a), subject to paragraph (4), the Secretary shall provide for payments under subsection (a) to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under this title.

"(2) PERMISSIBLE USES OF FUNDS.—The following are examples of innovative methods for which funds provided under this subsection may be used:

"(A) Methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs.

"(B) Methods for improving rates of collection from estates of amounts owed under this title.

"(C) Methods for reducing waste, fraud, and abuse under the program under this title, such as reducing improper payment rates as

measured by annual payment error rate measurement (PERM) project rates.

"(D) Implementation of a medication risk management program as part of a drug use review program under section 1927(g).

"(3) APPLICATION; TERMS AND CONDITIONS.—

"(A) IN GENERAL.—No payments shall be made to a State under this subsection unless the State applied to the Secretary for such payments in a form, manner, and time specified by the Secretary.

"(B) TERMS AND CONDITIONS.—Such payments are made under such terms and conditions consistent with this subsection as the Secretary prescribes.

"(C) ANNUAL REPORT.—Payment to a State under this subsection is conditioned on the State submitting to the Secretary an annual report on the programs supported by such payment. Such report shall include information on—

"(A) the specific uses of such payment;

"(B) an assessment of quality improvements and clinical outcomes under such programs; and

"(C) estimates of cost savings resulting from such programs.

"(4) FUNDING.—

"(A) LIMITATION ON FUNDS.—The total amount of payments under this subsection shall be equal to, and shall not exceed—

"(i) $50,000,000 for fiscal year 2007; and

"(ii) $50,000,000 for fiscal year 2008.

This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

"(B) ALLOCATION OF FUNDS.—The Secretary shall specify a method for allocating the funds made available under this subsection among States. Such method shall provide preference for States that design programs that target health providers that treat significant numbers of medicaid beneficiaries.

"(C) FORM AND MANNER OF PAYMENT.—Payment to a State under this subsection shall be made in the same manner as other payments under section 1903(a). There is no requirement

for State matching funds to receive payments under this subsection.

"(5) MEDICATION RISK MANAGEMENT PROGRAM.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'medication risk management program' means a program for targeted beneficiaries that ensures that covered outpatient drugs are appropriately used to optimize therapeutic outcomes through improved medication use and to reduce the risk of adverse events.

"(B) ELEMENTS.—Such program may include the following elements:

"(i) The use of established principles and standards for drug utilization review and best practices to analyze prescription drug claims of targeted beneficiaries and identify outlier physicians.

"(ii) On an ongoing basis provide outlier physicians—

"(I) a comprehensive pharmacy claims history for each targeted beneficiary under their care;

"(II) information regarding the frequency and cost of relapses and hospitalizations of targeted beneficiaries under the physician's care; and

"(III) applicable best practice guidelines and empirical references.

"(iii) Monitor outlier physician's prescribing, such as failure to refill, dosage strengths, and provide incentives and information to encourage the adoption of best clinical practices.

"(C) TARGETED BENEFICIARIES.—For purposes of this paragraph, the term 'targeted beneficiaries' means Medicaid eligible beneficiaries who are identified as having high prescription drug costs and medical costs, such as individuals with behavioral disorder or multiple chronic diseases who are taking multiple medications.".

SEC. 3144. ENHANCING THIRD PARTY IDENTIFICATION AND PAYMENT.

(a) CLARIFICATION OF THIRD PARTIES LEGALLY RESPONSIBLE FOR PAYMENT OF A CLAIM FOR A HEALTH

CARE ITEM OR SERVICE.—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended—

(1) in subparagraph (A), in the matter preceding clause (i)—

(A) by inserting ", including self-insured plans" after "health insurers"; and

(B) by striking "and health maintenance organizations" and inserting "health maintenance organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service"; and

(2) in subparagraph (G)—

(A) by inserting "a self-insured plan," after "1974,"; and

(B) by striking "and a health maintenance organization" and inserting "a health maintenance organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service".

(b) REQUIREMENT FOR THIRD PARTIES TO PROVIDE THE STATE WITH COVERAGE ELIGIBILITY AND CLAIMS

DATA.—Section 1902(a)(25) of such Act (42 U.S.C. 1396a(a)(25)) is amended—

(1) in subparagraph (G), by striking "and" at the end;

(2) in subparagraph (H), by adding "and" after the semicolon at the end; and

(3) by inserting after subparagraph (H), the following:

"(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, health maintenance organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to—

"(i) provide eligibility and claims payment data with respect to an individual who is eligible for, or is provided, medical assistance under the State plan, upon the request of the State;

"(ii) accept the subrogation of the State to any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;

"(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service submitted not later than 3 years after the date of the provision of such health care item or service; and

"(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim;".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section take effect on January 1, 2006.

(2) DELAYED EFFECTIVE DATE FOR CHAPTER.—in the case of a State plan under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the

requirements of such Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

SEC. 3145. IMPROVED ENFORCEMENT OF DOCUMENTATION REQUIREMENTS.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b), as amended by section 104 of Public Law 109-91, is amended—

(1) in subsection (i)—

(A) by striking the period at the end of paragraph (21) and inserting "; or"; and

(B) by inserting after paragraph (21) the following new paragraph:

"(22) with respect to amounts expended for medical assistance for an individual who declares under section 1137(d)(1)(A) to be a citizen or national of the United States for purposes of estab-

lishing eligibility for benefits under this title, unless the requirement of subsection (y) is met."; and

(2) by adding at the end, as amended by section 3104, the following new subsection:

"(y)(1) For purposes of subsection (i)(21), the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual.

"(2) The requirement of paragraph (1) shall not apply to an alien who is eligible for medical assistance under this title—

"(A) on the basis of being entitled or enrolled for benefits under any part of title XVIII;

"(B) on the basis of receiving supplemental security income benefits under title XVI; or

"(C) such other basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality had been previously presented.

"(3)(A) For purposes of this subsection, the term 'satisfactory documentary evidence of citizenship or nationality' means—

"(i) any document described in subparagraph (B); or

"(ii) a document described in subparagraph (C) and a document described in subparagraph (D).

"(B) The following are documents described in this subparagraph:

"(i) A United State passport.

"(ii) Form N-550 or N-570 (Certificate of Naturalization).

"(iii) Form N-560 or N-561 (Certificate of United States Citizenship).

"(iv) Such other document as the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.

"(C) The following are documents described in this subparagraph:

"(i) A certificate of birth in the United States.

"(ii) Form FS-545 or Form DS-1350 (Certification of Birth Abroad).

"(iii) Form I-97 (United States Citizen Identification Card).

"(iv) Form FS-240 (Report of Birth Abroad of a Citizen of the United States).

"(v) Such other document (not described in subparagraph (B)(iv)) as the Secretary may specify that provides proof of United States citizenship or nationality.

"(D) The following are documents described in this subparagraph:

"(i) Any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act.

"(ii) Any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.

"(E) A reference in this paragraph to a form includes a reference to any successor form.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to determinations of initial eligibility for medical assistance made on or after July 1, 2006, and to redeterminations of eligibility made on or after such date in the case of individuals for whom the requirement of section 1903(y) of the Social Security Act, as added by such amendments, was not previously met.

SEC. 3146. REFORMS OF TARGETED CASE MANAGEMENT.

(a) IN GENERAL.—Section 1915(g) of the Social Security Act (42 U.S.C. 1396n(g)) is amended by striking paragraph (2) and inserting the following:

"(2) For purposes of this subsection:

"(A)(i) The term 'case management services' means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

"(ii) Such term includes the following:

"(I) Assessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include the following:

"(aa) Taking client history.

"(bb) Identifying the needs of the individual, and completing related documentation.

"(cc) Gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual.

"(II) Development of a specific care plan based on the information collected through an assessment, that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual.

"(III) Referral and related activities to help an individual obtain needed services, including activities that help link eligible individuals with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

"(IV) Monitoring and followup activities, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be

with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as—

"(aa) whether services are being furnished in accordance with an individual's care plan;

"(bb) whether the services in the care plan are adequate; and

"(cc) whether there are changes in the needs or status of the eligible individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

"(iii) Such term does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred, including, with respect to the direct delivery of foster care services, services such as (but not limited to) the following:

"(I) Research gathering and completion of documentation required by the foster care program.

"(II) Assessing adoption placements.

"(III) Recruiting or interviewing potential foster care parents.

"(IV) Serving legal papers.

"(V) Home investigations.

"(VI) Providing transportation.

"(VII) Administering foster care subsidies.

"(VIII) Making placement arrangements.

"(B) The term 'targeted case management services' are case management services that are furnished without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B) to specific classes of individuals or to individuals who reside in specified areas.

"(3) With respect to contacts with individuals who are not eligible for medical assistance under the State plan or, in the case of targeted case management services, individuals who are eligible for such assistance but are not part of the target population specified in the State plan, such contacts—

"(A) are considered an allowable case management activity, when the purpose of the contact is directly related to the management of the eligible individual's care; and

"(B) are not considered an allowable case management activity if such contacts relate directly to the identification and management of the noneligible or nontargeted individual's needs and care.

"(4)(A) In accordance with section 1902(a)(25), Federal financial participation only is available under this title for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program.

"(B) A State shall allocate the costs of any part of such services which are reimbursable under another federally funded program in accordance with OMB Circular A-87 (or any related or successor guidance or regulations regarding allocation of costs among federally funded programs) under an approved cost allocation program.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2006.